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ABSTRACT

The importance of specific competencies and knowledge areas needed by bachelor level community health educators was examined through a survey of 67 practicing health educators in Maine who were members of public health educator associations. Respondents ranked 99 competencies in order of their perceived importance to professional practice. Results showed that process skills ranked higher in importance than cognitive health content. Behavioral concepts were rated higher in importance than liberal studies areas, and dealing with community groups was rated as most important. Lowest ranking competencies included foreign languages and environmental and administrative tasks. Work settings were a factor in determining the importance of required skills and role functions. Implications for professional preparation programs can be drawn from these findings, since they indicate the competencies required in different work environments. Tables are appended which show the highest and lowest ranking competencies, and the higher ranking competencies by work setting. (FG)

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The Specific Competencies of Bachelor Level Community Health Educators As Perceived by Maine Practicing Health Educators

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The Specific Competencies of Bachelor Level

Community Health Educators

As Perceived by Maine Practicing Health Educators

Introduction

The community health educator should be regarded as a valuable contributing member of the health care team. Increased national health care expenditures, societal concern about the quality of health care as well as access to health services, and a national trend towards the prevention of diseases and debilitating conditions with the increased utilization of educational strategies and techniques, has shifted public health policy towards the concepts of prevention and wellness. Key concepts or words new in the health educators vocabulary are including but not limited to: risk reduction, health promotion, and primary prevention. Health education as a strategy has been identified in Promoting Health Preventing Disease, the Surgeon General's objectives for the nation.[1] Prevention funds for risk reduction projects in some states are continuing, even with "Reaganomics." Thus, shifts in governmental policy, emphasizing disease prevention and positive health promotion, lend greater credibility to the health education profession.

During these last several years, health educators as a profession have been discussing and interacting about the competencies of entry level health educators. Identified by The Role Delineation Project[2] were seven areas of responsibility including: (1) Communicating Health and Health Education Needs, Concerns, and Resources; (2) Determining the

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Appropriate Forces for Health Education; (3) Planning Health Education Programs in Response to Identified Needs; (4) Implementing Planned Health Education Programs; (5) Evaluating Health Education, (6) Coordinating Selected Health Education Activities; and (7) Acting as a Resource for Health and Health Education. The final project report, 1981, identified the specific importance of various competencies by practice settings of schools, medical care, and community. However, many of the identified competencies were general in nature. This study was designed to identify the specific importance of selected competencies expected of bachelor level community health educators and had been conducted concurrently, but independently of the National Role Delineation Study.

Methods

The initial phase of the research project involved the identification of specific competencies expected of bachelor level community health educators. Examined were AAHPERS[3], A.S.H.A.[4] and S.O.P.H.E.[5] previously identified guidelines for preparation and practice, various higher education professional preparation competency programs, and several health educator job task analysis studies. From various materials, ninety specific competencies were identified in the broad areas of administration, general health knowledge, communication, and evaluation. Space was provided for the inclusion of additional competencies not listed in the original instrument. Potential respondents were requested to rate each of the competency items as follows:

"1" Would indicate little or no importance

"2" Would indicate some importance

"3" Would indicate average importance

"4" Would indicate above average importance

"5" Would indicate great importance

The developed survey instrument was reviewed by a jury of eighteen health education experts, with appropriate proportional members of experts practicing in the settings of community/public health agencies, medical care settings, schools, and higher education. The jury did not delete any of the identified competencies, but did add an additional nine competencies. Later, the survey instrument was field tested, utilizing a New England-based health education population, which excluded practicing health educators in Maine.

Respondents

This study was designed to measure the perceptions of bachelor's level health educator competencies in Maine. Individuals residing in holding membership in the Pine Tree Health Eduation Association; Society for Public Health Educators, Inc.; New England Chapter of the Society for Public Health Educators and; the American Public Health Association, School Health Section and Public Health Education Section were identified. Ninety practicing health educators were mailed the survey instrument and sixty-seven health educators responded, with a response rate of 74.4 percent.

Analysis of the Data

The sixty-seven respondents rated each of the ninety-nine competencies on a five-point scale. An average response for all respondents was established for each competency and later the competencies ranked by the settings of community/public health agency (N=16), the medical care setting (N=22), schools (N=8), Higher Education (N=13), and not given, (N=8). The twenty-five highest ranking competencies by all respondents are found in Table 1.

In analyzing the most important competencies, several conclusions may be drawn. For example process skills are more important than cognitive health content. Mentioned as the only health content areas were Mental Health and Nutrition, whereas numerous process skills are listed such as: Utilization of Multi-Media; Developing Educational Materials; Public Relations; Adult Learning; Program Evaluation; Educational Strategies; Identification of Health Education Resources; Community Organization; and Development of Educational Strategies. Also, behavioral related concepts are more important than liberal studies ideas. Psychology; Small Group Proceses; Interacting with Own Staff; Mental Health and; Decision-Making Processes are all cited. In addition, working with the community and community related groups is most important. Ranked highly are such competencies as: Small Group Process; Developing Rapport with Community Leaders; Community Organization/ Coordinator; Organization of Community Interest Groups; Conducting In-service Programs; Communicating with the Medical Profession; Public Relations; Speaking to Various Community Leaders; and Conducting Health

Programs for Schools. Lastly, many of the higher ranking competencies include fully developed oral and/or non-verbal communication skills, e.g., Working with Various Groups and Talking to Different Community Leaders.

While reviewing lowest ranking competencies (Table 2), concluded that foreign language, environmental and administrative tasks assume lesser importance. For example, Land, Water, Air, and Noise Pollution are listed, as well as administrative tasks related to Agency Contracts, Recruitment of Personnel; Directing Research Projects; Cost Accounting; Fund Raising; Office Management and; selected budget tasks.

In reviewing higher ranking competencies by work practice settings several concerns surface. Some competencies for example were ranked similiar in importance no matter the setting of practice. Examples of such include: Educational Strategies; Health Care System; Organization of Community Interest Groups or; Speaking to Community Leaders. Other competencies are ranked in the top twenty-five but are ranked differently in various practice settings. For example, Identification of Health Education Resources is ranked #1 by medical care, #2.5 in the schools, #9 by higher education, and #16.5 by community/public health. This indicates that two settings are extremely concerned while another setting is not. Similiar reactions were also obtained for: Program Planning; Community Organization; Projecting Enthusiasm for Health Education; Small Group Process; or Staff Interactions. Lastly, some competencies are ranked higher in only one or two practice settings. These include: MBO evaluation in higher education; Sociology in the

school settings or Consumer Groups in the community and public health setting.

Some direct observations can be gained from the data: For example, a health educator practicing in the schools requires greater knowledge in health cognitive content as exhibited by rankings received by Nutrition, Family Life, Tobacco, Human Sexuality, Drugs, First Aid, and Safety Hazards. In addition, higher education health educators possess different perceptions of ranking than field-based practitioners. For example, higher education health educators ranked evaluation tasks and skills higher than the other practice settings. Another example is the lower ranking in areas related to community organization tasks, such as Public Relations, Working with Consumer Groups, or Health Counseling. Lastly, settings of practice can assist in determining specific role functions. For example: Communicating with the Medical Profession is ranked #8.5 and #12 respectively by community/public health and medical care, ranked only at #28 by higher education and not listed by the school setting. On the other hand, Conducting Health Programs for Schools was ranked #6 by the school setting and #'s 30, 29, and 24.5 by community and public health, medical care setting, and higher education respectively. In addition, Conducting In-service Programs was mentioned only by the medical system ranked #16.

Implication For Professional Preparation Programs

In addition to reviewing and comparing the importance of competencies by practice settings, inferences can be made related to the specific nature of professional preparation programs. For example,

in the community/ public health setting, more important health content areas should include Mental Health and Nutrition. Program planning tasks are vital, as indicated by the ranking of Education Strategies, Program Evaluation, Utilization of Multi-Media, Identification of Health Education Resources, and Adult Learning. Communication tasks are necessary to carry out assigned tasks as indicated by Projecting Enthusiasm for Health Education, Small Group Process Techniques, Working with Consumer Groups, and Communicating with the Medical Profession. Lastly, community organization techniques are vital, such as: Small Group Process, Working With Consumer Groups, Communicating With The Medical Profession, Organizing Community Interest Groups, Community Organization/ Coordinating/Coordinating, Public Relations, and Developing Rapport With Community Leaders.

A health educator practicing in the medical care setting needs to possess skills and expertise in several different areas. Program planning skills appeared to be of upmost importance as indicated by the higher rankings received for Identification of Health Education Resources; Small Group Process Techniques; Making Presentations; Adult Learning; Educational Strategies; and Program Evaluation. In addition, staff training processes appear to be important, according to the higher rankings Providing In-service Training; Making Presentations; and Developing Educational Materials received. Also, the concept of providing technical assistance is valued due to the rankings of: Identification and Utilization of Health Education Resources; Developing In-service Materials; Health Counseling Techniques; In-service Training;

and Working With Adult Populations. Lastly, hospitals, like any other business, operate utilizing a Management by Objectives mechanism and, therefore, knowledge in this area is important.

Health Educators practicing in the school setting require somewhat different competencies than those practicing in other settings. For example, mentioned as important competencies are various health content areas such as Mental Health; Nutrition; Tobacco; Family Life; Human Sexuality; Industrial Safety; First Aid; and Safety Hazards. Not mentioned, for example, are selected community organization tasks, probably due to the fiscal arrangements of most schools. Lastly, important in the school setting in addition to health content, are tasks related to program planning, implementation, and evaluation, as indicated by the higher rankings received by Identification of Health Education Resources; Educational Strategies; Conducting Programs for Schools; Developing Educational Materials; Program Evaluation; and Making Presentations.

Several assumptions can be made from the analysis of rankings from data related to higher education. For example, in this setting, indicated is a greater emphasis on evaluation and measurement techniques as indicated by the rankings of Program Evaluation; Evaluation of Management by Objectives; Learning Domains; Pre-Post Testing Procedures; Behavior Tests; and Developing Surveys. In addition, community organization strategies appeared to be more important than program planning/implementation/ evaluation skills, as indicated by the ranks of the various competencies. Lastly, process skills appear to be more important than health facts or content as noted by Mental Health being the only content area ranked.

Implementations for the Profession

The results of this study have important ramifications for both practitioners and faculty associated with undergraduate community health education programs. This study, along with the Role Delineations Study, has indicated that health educators practicing in different settings should possess differing competencies dependent in part upon agency policies/procedures for conducting health education activities and the target populations health education needs and interest. A need thus exists for professional preparation programs to fully examine their undergraduate programs to see if a reality-orientated product is the end result. Students too should be called upon to determine both short term and long term career goals that will assist them in locating employment positions, as well as preparing them to function effectively in their setting of practice.

TABLE 1

Twenty-five Highest Competencies for all Respondents (N=67)

Rank	Average	Competency
1	4.61	Educational Strategies
2	4.52	Identification of Health Education Resources
3	4.51	Projecting Enthusiasm for Health Education
4	4.50	Health Care System
5	4.49	Program Evaluation
6	4.38	Small Group Process Techniques
7	4.37	Program Planning/Development
8	4.34	Interacting with Own Staff
9	4.32	Developing Rapport with Community Leaders
10	4.31	Adult Learning
12	4.28	Community Organization/Coordination
12	4.28	Mental/Emotional Health
12	4.28	Organization of Community Interests Groups
14	4.21	Decision-Making Processes
15	4.20	Conducting Community Service Programs
16.5	4.18	Developing Educational Materials
16.5	4.18	Communicating with the Medical Profession
18	4.17	Principles of Public Health
20	4.14	Public Relations
20	4.14	Nutrition
20	4.14	Human Growth and Development
22	4.11	Speaking to Various Community Leaders
23	4.10	Conducting Health Programs for Schools
24	4.07	Psychology
25	4.05	Utilization of Multi-Media During Presentations

TABLE 2

Lowest Ranking Competencies for all Respondents

Rank	Average	Competency
99	1.56	German
98	1.66	Spanish
97	2.33	French
96	2.45	Preparation of Agency Contracts
95	2.46	Negotiation of Agency Contracts
94	2.59	Directing Research Projects
93	2.60	Recruitment of Agency Personnel
92	2.78	Cost Accounting
91	2.83	Recruitment of Future Mental Educators
90	2.89	Fund Raising
89	2.90	Use of Computer Facilities
88	2.92	Office Management
87	3.07	Information Systems Planner
86	3.11	Administrative Models
85	3.19	Land Pollution
84.5	3.20	Water Pollution
84.5	3.20	Air Pollution
82	3.21	Business Communications
81	3.23	Noise Pollution
79	3.25	Industrial Safety
79	3.25	Grant Writing
79	3.25	Writing Professional Articles
77	3.32	Occupational Safety
76	3.37	Utilization of Research Data from Professional Journals
75	3.38	Budget Analysis and Planning

TABLE 3

Higher Ranking Competencies by
Practice Settings

Competency	Community/Public Health N=16		Medical Care N=22		Schools N=8		Higher Education N=13	
	Average	Rank	Average	Rank	Average	Rank	Average	Rank
Identify Health Education Resources	4.31	16.5	4.63	1	4.75	2.5	4.38	9
Project Enthusiasm For Health Education	5.00	1	4.50	3 17.5	4.37 4.69	 1		
Educational Strategies	4.81	2	4.40	5.5	4.62	6	4.61	2.5
Small Group Processes	4.75	3.5	4.54	2	4.50	10.5	4.54	4.5
Program Planning	4.18	30	4.36	8.5	4.75	2.5	4.33	10
Staff Interactions	4.43	10	4.22	15	4.75	2.5	4.23	18.5
Sociology					4.75	2.5		
Program Evaluation	4.75	3.5	4.38	7	4.50	10.5	4.46	6.5
Making Presentations			4.47	4	4.37	17.5	4.30	13.5
Community Organization	4.31	16.5	4.00	26	4.37	17.5	4.53	4.5
Health Care System	4.56	6	4.36	8.5	4.62	6	4.41	8

TABLE 3 (Cont.)

Competency	Community/Public Health N=16		Medical Care N=22		Schools N=8		Higher Education N=13	
	Average	Rank	Average	Rank	Average	Rank	Average	Rank
Adult Learning	4.31	16.5	4.40	5.5			4.07	24.5
Mental Health	4.56	6	4.13	17.5			4.15	21.5
Consumer Groups	4.56	6						
Cond. School Programs	4.18	30	3.95	29	4.62	6	4.07	24.5
Nutrition	4.50	8.5	4.04	24	4.37	17.5		
Communicate Medical Profession	4.50	8.5	4.28	12			4.00	28
Behavioral Tests	4.25	23.5	4.36	8.5			4.00	28
Public Relations	4.31	16.5	4.09	20	4.50	10.5		
Alcohol					4.50	10.5		
Develop Rapport - Community Leaders	4.25	23.5	4.31	10	4.50	10.5	4.30	13.5
Psychology	4.37	12	4.00	26				

TABLE 3 (Cont.)

Competency	Community/Public Health N=16		Medical Care N=22		Schools N=8		Higher Education N=13	
	Average	Rank	Average	Rank	Average	Rank	Average	Rank
Conduct In-Service			4.17	16				
M.B.O.			4.13	17.5				
Family Life			4.00	26	4.37	17.5		
Speaking to Community Leaders	4.18	30	4.04	24	4.37	17.5	4.07	24.5
Provide Technical Assistance					4.37	17.5	4.07	24.5
Decision-Making Models							4.23	18.5
Public Health Principles	4.25	23.5			4.25	25.5		
Physiology	4.25	23.5						
Health Counseling	4.18	30	4.04	24				
Human Sexuality					4.25	25.5		

TABLE 3 (Cont.)

Competency	Community/Public Health N=16		Medical Care N=22		Schools N=8		Higher Education N=13	
	Average	Rank	Average	Rank	Average	Rank	Average	Rank
Multi-Media Utilization	4.37	12	4.09	20				
Decision-Making Processes	4.37	12	4.09	20	4.25	25.5	4.61	25
Coordinate Community Service	4.31	16.5	4.28	12	4.14	30	4.23	18.5
Develop Education Materials	4.25	23.5	4.28	12	4.50	10.5	4.23	18.5
Human Growth	4.25	23.5			4.25	25.5	4.30	13.5
Domains	4.25	23.5					4.30	13.5
Pre-Post Tests	4.25	23.5	4.05	22			4.30	13.5
MBO Evaluation							4.30	13.5
Organization Community Interest Groups	4.31	16.5	4.27	14	4.37	17.5	4.15	21.5

TABLE 3 (Cont.)

Competency	Community/Public Health N=16		Medical Care N=22		Schools N=8		Higher Education N=13	
	Average	Rank	Average	Rank	Average	Rank	Average	Rank
Drugs					4.25	25.5		
First Aid					4.25	25.5		
Safety Hazards					4.25	25.5		
Attitude Tests	4.18	30			4.25	25.5		
Develop Surveys							4.00	28

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